Peer Review File

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Reviewer A

Comment 1: On page 4 line 82 the authors state that each patient group was operated by a single surgeon. Does this mean that surgeon A operated all of the transperitoneal group and surgeon B operated all of the extraperitoneal group?
If so, this study is about a comparison of two different surgeons, not of two different operative approaches. The data simply indicates the surgeon A is technically superior to the surgeon B.
Reply 1: No, both surgeons operated in both group.
Changes in the text: I have delated that sentence and add “The surgeons performed both techniques.” we have modified our text as advised (see Page 4, line 82)".

Comment 2: This point is also related to the patient selection. If a patient sees the surgeon A, he receives transperitoneal surgery. If another patient sees the surgeon B, he receives extraperitoneal surgery. Is my understanding correct? I want the authors to clarify this point.
Reply 2: I answered that both surgeons operate both techniques and deleted that sentence.
Changes in the text: I have deleted that sentence.
we have modified our text as advised (see Page 4, line 82)". The surgeons performed both techniques.

Reviewer B

Comment 1: This study shows some interesting results, unique in that fact that few studies directly compare extraperitoneal vs. intraperitoneal prostatectomies by the same surgeon as not too many surgeons are experienced in both approaches
Reply 1: Both surgeons performed both technique
Changes in the text: we added some data “The surgeons performed both techniques.” (see Page 4, line 82)"

Comment 2: Advantages and disadvantages between extraperitoneal vs. transperitoneal lap prostate surgery include the fact that there is better visualization and working space in the transperitoneal approach so the length of surgery that is decreased in this group makes sense, but a disadvantage would be exposure to the bowel contents in the abdomen and potential for urine leak to irritate the peritoneum so one would assume that hospital stay would be longer compared to extraperitoneal, due to complications such as ileus and irritation from urine leak etc. Surprising that this study does not show any sig. difference between these complications (rate of complications are similar) and also surprisingly that transperitoneal prostatectomy stayed on average shorter in hospital post op compared to extraperitoneal.
Blood loss less due to better visibility in transperitoneal, this would make sense.

Higher positive surgical margin and BCR in extraperitoneal group, no change in urinary function, better sexual function (erections) at 12 weeks in transperitoneal group.
Reply 2: From the fact that you mention as known, our results about complications were not significant. For transperitoneal prostatectomy stayed on average shorter in hospital post op compared to extraperitoneal exactly that may from some causes.
Changes in the text: we have not added any text as advised.

Comment 3: Blood loss less due to better visibility in transperitoneal, this would make sense. Higher positive surgical margin and BCR in extraperitoneal group, no change in urinary function, better sexual function (erections) at 12 weeks in transperitoneal group
Reply 3: These results may be not answer because we felt as you mentions and thank you.
Changes in the text: no

Comment 4: Limitations to study including small N number in each group, the fact that there was no randomization in the patient population, the patient was offered intraperitoneal or transperitoneal prostatectomies based on surgeon preference, this could introduce selection bias in the results
Reply 4: This comment was answer in text
Changes in the text: Page 11 line 232-233

Comment 5: These results suggest that for all perioperative and post op outcomes, transperitoneal is equivalent if not superior to extraperitoneal.
Most surgeons are probably more comfortable with transperitoneal due to recent advances in robotic surgery.
This study supports the trend of increasingly common and popular intraperitoneal prostatectomies using MIS technology compared to extraperitoneal prostatectomies
Clinical applications: most urologists are not currently comfortable or well-trained in performing extra-peritoneal prostatectomies. This study which shows less blood loss, shorter hospital stay, reduced operative time, lower BCR and positive margins, no significant change in functional and post op outcomes in terms of sexual function, urinary function support the fact that extraperitoneal prostatectomies might become a defunct practice in the future.
Reply 5: thank you for your comment
Changes in the text: no.

Reviewer C
Comment 1: It would be important if authors describe each one of the techniques performed by the group and also explain when was the beginning of each one of them. Both surgeons began to perform radical prostatectomy at the same time?
Reply 1: The surgeons performed both techniques at the same beginning time.
Changes in the text: I have delated that sentence and add “The surgeons performed

both techniques.” we have modified our text as advised (see Page 4, line 82)".

Comment 2: in literature, there is a debate about how long is the learning curve of a laparoscopic radical prostatectomy. Some papers describe that the first 200 procedures should be performed to some surgeons surpass their learning status. This is questionable, but in your study even after 10 years your group performed a total of only 170 procedures. This is clearly a bias in your study. Authors should appropriately describe this important limitation.
Reply 2: Our surgeons in this research had more that only 100 learning curve laparoscopic cases that less than 200 procedures that you mentions, but 100 cases included many type of laparoscopic surgery. In this point may affect some bias.
Changes in the text: no add more information.

Comment 3: What is the percentage of open and laparoscopic radical prostatectomies in your group?
Reply 3: 100% in laparoscopic radical prostatectomy
Changes in the text: no

Comment 4: One of advantages of minimally invasive radical prostatectomies is the reduction of length of stay at the hospital. In your series, the median time to discharge was seven days in the transperitoneal group and 4.5 days in the extraperitoneal group. In literature, many series describe a median time of only 2-4 days. Please, authors should better explain this.
Reply 4: Thank you and for Thai patients usually need to stay in hospital until feel comfortable before discharge with full finance coverage from government that impact to prolong hospital stay than in literatures.
Changes in the text: no

Comment 5: Interesting point that a significant proportion of cases were classified as Gleason 3+3 (ISUP 1) in both groups, but authors related a high proportion of high-risk patients staged as pT2c - pT3b. How can authors could explain this disparity?
Reply 5: thank you and this disparity was some interesting aspects. We did not analyze the correlation of Gleason 3+3 and high risk but most of them may majority in T2c group
Changes in the text: no

Comment 6: Authors defined CONTINENCE as "No use of pads". However, in Table 2 was described the continence status up to 1 pad and at least 2 pads after 4 and 12 weeks.
Reply 6: Thank you for correction in table from <= 1 pad a day should be change to no pad a day
Changes in the text: we have modified our table 2 as advised.

Comment 7: The positive surgical margin status was stated in a proportion higher

than the published literature (20.6% and 42.2%). Does this fact could be explained only by the initial learning curve in both techniques?
Reply 7: Thank you and the answer was yes as you mentions.
Changes in the text: no

Comment 8: Another potential advantage of minimal invasive procedures is a less blood loss comparing to open radical prostatectomies. In your series, it may be considered that your median blood loss was high (800mL and 400mL in both each group). This variable could be explained by your position in a learning curve. Any other points to explain that?
Reply 8: Thank you for your comments and I think the learning curve may be the most factors and there are some step that we did not suture dorsal venous plexus and used vessel sealing to cauterize dorsal venous plexus
Changes in the text: no